



## Health Benefits for Providers Invoice Cover Sheet

**For the Month of \_\_\_\_\_, 20\_\_\_\_**

1. Total Amount from Blue Cross/ Blue Shield Invoice: \$ \_\_\_\_\_
  - A. Additional Amount Paid Since Invoice Generated - \$ \_\_\_\_\_
  - B. Terminated Employees Adjusted Off Bill - \$ \_\_\_\_\_
  - C. Other (Describe) \_\_\_\_\_ + or - \$ \_\_\_\_\_
  
2. Total Adjustments Made to BC/BS Invoice (*Add Lines A-C*) + or - \$ \_\_\_\_\_
3. Total Paid to BC/BS This Month (*Subtract Line 2 from Line 1*): = \$ \_\_\_\_\_

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4. Check Amount (Enter Amount from Line 3) \$ \_\_\_\_\_
  - D. Employee Portion Due (\$35 per employee **per month**):  
 Number of Employee Portions Due \_\_\_\_\_ X \$35 = \$ \_\_\_\_\_
  - E. Employer Portion Paid (\$70 per employee **per month**):  
 Number of Employer Portions Due \_\_\_\_\_ X \$70 = \$ \_\_\_\_\_
  - F. Billed Dependent Expenses \$ \_\_\_\_\_
  - G. Other (Description) \_\_\_\_\_ \$ \_\_\_\_\_
5. Total Adjustments Made to CCPFC Portion (*Add Lines D-G*): \$ \_\_\_\_\_
6. Total Partnership Portion to Pay (*Subtract Line 5 from Line 4*): \$ \_\_\_\_\_

Requestor Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

***Please attach a copy of your BC/BS Invoice for this month along with a copy of personnel records showing participating employees' hours and insurance deduction!***

<b>APPROVED FOR PAYMENT:</b>	
_____ Constance Sowers, Program Coordinator	_____ Date
_____ Sherry Peel, Executive Director	_____ Date